

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

## 1. PLACE OF DEATH:

County Caroline  
 City or town Federalburg - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 28 years  
 Hospital, institution, or street address where death occurred:  
Halbertown  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Caroline  
 City or town Federalburg - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Halbertown  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war 76

## 3. (a) FULL NAME

Henry F. Andrew

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 8. (b) Name of husband or wife

A. Victoria Andrew

## 7. Birth date of deceased (mo., day, yr.)

December 11, 1859

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

5783

\_\_\_\_ hrs. \_\_\_\_ min.

## 9. Birthplace

Caroline County, Maryland  
(Town, county, and state)

## 10. Usual occupation

Retired Carpenter

## 11. Industry or business

House Carpenter

## FATHER

12. Name Newton Andrew13. Birthplace Caroline County, Maryland

## MOTHER

14. Maiden name Elizabeth Griffith15. Birthplace Caroline County, Maryland

## 16. Informant

Mrs. Oral Christopher

## Address

Federalburg, Maryland

## 17.

Burial  
(Burial, cremation, or removal. Which?)Date thereof August 15 1947  
(month) (day) (year)

## Cemetery or crematory

High Crest Cemetery

## Location

Federalburg, Maryland

## 18. Funeral director

J. J. Frampton and Son

## Address

Federalburg, Maryland

## 19.

August 15, 1947  
(Date rec'd by registrar)J. J. Frampton  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1947 at 1:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 15 1947 to Aug 14 1947and that I last saw him alive, on August 14 1947Immediate cause of death Chronic Myocarditis

## DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Malnutrition

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

Address \_\_\_\_\_

M. D. or other

Date signed 8-15-47

RECEIVED  
AUG 18 1947  
BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46d

06871

## CERTIFICATE OF DEATH

Reg. Dist. No. 61

## 1. PLACE OF DEATH:

County CarolineCity or town Greensboro  
(if outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 mo. 12 da.

Hospital, institution, or street address where death occurred:

Steward's Convalescent HomeHow long in hospital or institution? 1 mo. 12 da.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Dorchester  
(if outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Lincoln Arnold

## 3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Widowed8. (b) Name of husband or wife Catherine Arnold7. Birth date of deceased (mo., day, yr.) August - 1861

5. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 86 Months \_\_\_\_\_ Days \_\_\_\_\_

If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

8. Birthplace Michigan

(Town, county, and state)

10. Usual occupation Retired11. Industry or business Farmer12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant William FisherAddress Easton, Md.17. Burial Date thereof Aug. 25, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Spring HillLocation Easton, Md.18. Funeral director J. E. ClarkAddress Easton, Md.19. 8/22 1947 N. J. Neuner

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1947, at 1:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 12 1947, to Aug. 1947.and that I last saw him alive on August 20 1947.Immediate cause of death Death Mellitus

DURATION

(1)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Cerebral Aneurysm

(Includes pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Charles H. Neuner

M. D. or other

Address Greensboro, Md. Date signed \_\_\_\_\_

RECEIVED

AUG 29 1947

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06872

Reg. Dist. No. 62

## 1. PLACE OF DEATH:

County CarolineCity or town Denton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CarolineCity or town Denton  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name War \_\_\_\_\_

## 3. (a) FULL NAME

Howard Linwood Brown

## 3. (b) Social Security Number

4. Sex M 5. Color or race N 6.(a) Single, married, widowed, or divorced W6.(b) Name of husband or wife Louise Brown7. Birth date of deceased (mo., day, yr.) July 28, 1877 6.(c) If alive, give age 60 years8. AGE: Years 70 Months 0 Days 11 If less than one day, hrs. 104 min.9. Birthplace Burrville, Caroline, Maryland  
(Town, county, and state)10. Usual occupation Farmer

## 11. Industry or business

12. Name Thomas Brown13. Birthplace Burrville, Md.14. Maiden name Laura [unknown]15. Birthplace Burrville, Md.16. Informant Laura BrownAddress Denton, Md.17. Burial Date thereof Aug 11, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Denton, Md.Location Denton, Maryland18. Funeral director J. Virgil HarrisonAddress Denton, Maryland19. 8/11 1947 M. D. George

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1947, at 11:55 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 24 1939 to August 7 1947and that I last saw him alive on August 7 1947Immediate cause of death central leukemia

DURATION

10 d

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Hypertension5 yr

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

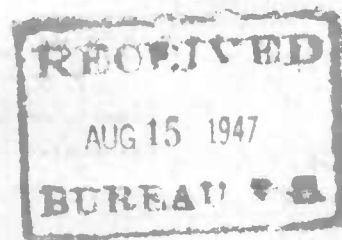
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE St Paul Thotts

M. D. or other

Address Denton, Md Date signed 8/9/47





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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

06873

66

## 1. PLACE OF DEATH:

County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death.....  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

Male White Married

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....

8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min.

9. Birthplace.....

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial..... Date thereof.....

(Burial, cremation, or removal of which?)..... (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Aug 18 1947 J D Davis

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....  
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

218-20-5888

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... at.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....

and that I last saw him alive on.....

Immediate cause of death.....

Other conditions.....

Due to.....

Due to.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

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AUG 19 1947

BUREAU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore 926  
CERTIFICATE OF DEATH

06874

Reg. Dist. No. 60

## 1. PLACE OF DEATH:

County Caroline  
City or town Henderson Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 year  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State md County Caroline  
City or town Henderson Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Henry Grofelmauer

## 3. (b) Social Security Number

4. Sex m. 5. Color or race w 6. (a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife Annie

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1867 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 79 Months 4 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Germany  
(Town, county, and state)

10. Usual occupation Merchant

11. Industry or business

12. Name Frank Grofelmauer13. Birthplace Germany14. Maiden name Unknown15. Birthplace md16. Informant Miss Charlotte MixAddress Henderson md17. Burial Date thereof Aug. 11, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory LutheranLocation New York, N.Y.18. Funeral director Raymond B. PawlowskiAddress Lewisburg md19. 8/6/ 19 47 A. Clark Smith

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH August 6 19 47 at 10:50 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5 19 47 and that I last saw him/her alive on Aug 5 19 47

and that I last saw him/her alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_ DURATION

Due to StrokeDue to Heart troubleOther conditions See above

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Raymond B. Pawlowski M. D. or otherAddress Chesapeake Beach Md Date signed Aug 6

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SEP 3 1947

BUREAU V.A.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1242

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

## 1. PLACE OF DEATH:

County CarolineCity or town Denton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15-yrHospital, institution, or street address where death occurred:  
none

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Denton  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Genevieve Lane

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

William Lane6. (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.)

Aug 13, 1913

8. AGE:

Years 33Months 11Days 24

If less than one day

hrs. \_\_\_\_\_

min. \_\_\_\_\_

9. Birthplace

Baltimore, Baltimore, Md.  
(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

FATHER  
MOTHER

12. Name

John S. Scratch

13. Birthplace

Baltimore

14. Maiden name

Mary [unknown]

15. Birthplace

Baltimore

16. Informant

William Lane

Address

Denton, Maryland

17.

(Burial, cremation, or removal, which?)

Burial

Date thereof

Aug 11, 1947  
(month) (day) (year)

Cemetery or crematory

Denton

Location

Denton, Maryland

18. Funeral director

J. Virgil Moore & Son

Address

Denton, Maryland

19.

(Date rec'd by registrar)

8/1147M.D.O. [signature]

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

August 7

19

47 at 7:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 6

19

47

to

August 7

19

47

and that I last saw him alive on

August 6

DURATION

4 years+

Immediate cause of death

Cirrhosis of Liver

Due to

Presumed alcoholic in origin

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. Paul Truitt M.D.

M. D. or other

Address

Denton, Md

Date signed

8/9/47

RECEIVED

AUG 15 1947

BUREAU OF

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

06876

## CERTIFICATE OF DEATH

1. PLACE OF DEATH: *Caroline*  
 County *Greensboro Rural*  
 City or town *3 days*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State *Maryland* County *Caroline*  
 City or town *Greensboro Rural*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME *Donald Nichols*

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *Col.* 6. (a) Single, married, widowed, or divorced *Single*

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) *Aug. 17 - 1947* 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years *0* Months *0* Days *3* If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace *Greensboro Caroline, Md.*  
 (Town, county, and state)

10. Usual occupation *None*

11. Industry or business \_\_\_\_\_

12. Name *Frank Eadsen*

13. Birthplace *Georgia*

14. Maiden name *Mary Nichols*

15. Birthplace *Maryland*

16. Informant *Melvin Nichols*

Address *Greensboro Rural, Md.*

17. *Burial* Date thereof *8/20/47*  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory *Saint Paul*

Location *Wilston Maryland*

18. Funeral director *R. B. Rawlings*

Address *Greensboro, Md.*

19. *8/20* 19 *47* *L. Mae Pippin*  
 (Date rec'd by registrar) (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug. 19* 19 *47* at *1 P.* M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Aug 17* 19 *47*, to *Aug 19* 19 *47*, and that I last saw him alive on *Aug 19* 19 *47*

Immediate cause of death *Cerebral hemorrhage*

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE *Charles H. Henshaw* M. D. or equivalent

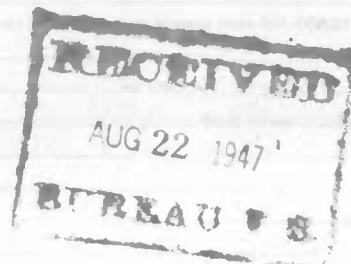
Address *Greensboro, Md.* Date signed *8/20/47*

Registrar 11 Address \_\_\_\_\_ Date signed \_\_\_\_\_

MARGIN RESERVE FOR BINDING

VS A15 9.4

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

## 1. PLACE OF DEATH:

County Caroline  
 City or town Federalburg - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
Houston Branch Road  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Caroline  
 City or town Federalburg - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Houston Branch Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Luther Nichols

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Ila L. Nichols  
 7. Birth date of deceased (mo., day, yr.) May 12, 1874 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 73 Months 2 Days 22 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Caroline County, Maryland  
 (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business Farm  
 12. Name Leonard Nichols  
 13. Birthplace Caroline County, Maryland  
 14. Maiden name Martha Ann Nichols  
 15. Birthplace Caroline County, Maryland  
 16. Informant Miss Lula R. Nichols  
 Address 1201 - 13<sup>th</sup> Street, N.W. Washington, D.C.  
 17. Burial Date thereof August 7, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Will Crest Cemetery  
 Location Federalburg, Maryland  
 18. Funeral director J. J. Frampton and Son  
 Address Federalburg, Maryland  
 19. August 7 19 47 S. J. Frampton  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH August 4 19 47 at 5:10 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1<sup>st</sup> 1947 to Aug 4<sup>th</sup> 1947  
 and that I last saw him alive on 8-1-47  
 Immediate cause of death \_\_\_\_\_

Coronary thromboses 5 hr.  
 Due to \_\_\_\_\_  
Chronic myocarditis  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Frank M. Jones M.D.  
Federalburg, Md. M. D. or other \_\_\_\_\_  
 Address \_\_\_\_\_ signed 8/7/47



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AUG 11 1947  
BUREAU 11

PLEASE WRITE PLAINLY, WITH LEADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

06878

## 1. PLACE OF DEATH:

County CarolineCity or town Federalburg - Rural  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

American Corner

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State South Carolina County FlorenceCity or town Lake City  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Janie Peterson

## 3. (b) Social Security Number

248-18-5853

## 4. Sex

Female

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Singleton Peterson6. (c) If alive, give age 30 years

## 7. Birth date of deceased (mo., day, yr.)

July 12, 1920

## 8. AGE:

Years

Months

Days

If less than one day

2711

hrs.

min.

## 9. Birthplace

Neeseham, South Carolina  
(Town, county, and state)

## 10. Usual occupation

Day laborer

## 11. Industry or business

Factory (Canning)

MOTHER FATHER

## 12. Name

Samuel Session

## 13. Birthplace

South Carolina

## 14. Maiden name

Lillie Montgomery

## 15. Birthplace

South Carolina

## 16. Informant

Mrs. Lillie Session

## Address

Federalburg, Maryland, R.F.D.

## 17. Removal

(Burial, cremation, or removal. Which?)

Date thereof August 13, 1947  
(month) (day) (year)

## Cemetery or crematory

Lake City

## Location

Lake City, South Carolina

## 18. Funeral director

J. J. Frampton and Son

## Address

Federalburg, Maryland

## 19. August 19, 1947

(Date rec'd by registrar)

J. J. Frampton  
Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH August 13, 1947 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on August 13, 1947 at 5:15 P.M.

Immediate cause of death

DURATION

Due to

Shock.  
Struck by Lightning

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

Dr. J. J. Frampton  
M. D. or other \_\_\_\_\_  
Address Federalburg Date signed 8/16/47

RECEIVED  
AUG 19 1947  
BUREAU OF

06879

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93a

## CERTIFICATE OF DEATH

Reg. Dist. No. 60

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
County..... <u>Caroline</u>		(For newborn infants give residence of mother)	
City or town..... <u>Holdsboro Rural</u>		State..... <u>Maryland</u> County..... <u>Caroline</u>	
(If outside city or town limits, write RURAL and give nearest town)		City or town..... <u>Holdsboro</u>	
How long in above place of death?..... <u>20 yrs.</u>		(If outside city or town limits, write RURAL and give nearest town)	
Hospital, institution, or street address where death occurred:		Street No.....	
		(If rural, give LOCATION)	
How long in hospital or institution?.....		2(a) If veteran, name war.....	

3. (a) FULL NAME	3. (b) Social Security Number
<u>Alonzo Stanford</u>	<u>216-18-8860</u>

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Male</u>	<u>Col.</u>	<u>Married</u>
6. (b) Name of husband or wife..... <u>Ada</u>		
6. (c) If alive, give age..... <u>53</u> years		
7. Birth date of deceased (mo., day, yr.)..... <u>Oct. 10 1889</u>		
8. AGE:	Years	Months
<u>57</u>	<u>10</u>	<u>21</u>
Days..... hrs..... min.		

9. Birthplace..... <u>Greensboro, Caroline, Md.</u>
(Town, county, and state)

10. Usual occupation..... <u>Farmer</u>
---

11. Industry or business.....
-------------------------------

FATHER	12. Name..... <u>Renolds Stanford</u>
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13. Birthplace..... <u>Maryland</u>
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MOTHER	14. Maiden name..... <u>Lida Brown</u>
--------	--

15. Birthplace..... <u>Maryland</u>
-------------------------------------

16. Informant..... <u>Mrs. Ada Stanford</u>
---

Address..... <u>Holdsboro, Md.</u>
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17. <u>Burial</u>	Date thereof..... <u>9/3/47</u>
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(Burial, cremation, or removal. Which?)	(month) (day) (year)
---	----------------------

Cemetery or crematory..... <u>Union</u>
---

Location..... <u>Near Greensboro, Md.</u>
---

18. Funeral director..... <u>R. B. Rawlings</u>
---

Address..... <u>Greensboro, Md.</u>
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19. <u>Sept. 3 47</u>	<u>a. Clark Smith</u>
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(Date rec'd by registrar)	Registrar
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## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug. 31..... 19..... 47..... at..... 10 A...... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1..... 19..... 46..... to..... Aug. 31..... 19..... 47.....and that I last saw him alive on..... Aug. 30..... 19..... 47.....

Immediate cause of death.....

Acute Myocarditis

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Address.....

Date signed..... 1947

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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SEP 16 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

920

06880

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Caroline  
City or town Henderson  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 21 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md. County Caroline  
City or town Henderson  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

RUTH STUBBS

3. (b) Social Security Number

4. Sex fi 5. Color or race W. 6.(a) Single, married, widowed, or divorced married.  
6.(b) Name of husband or wife William E. Stubbs  
6.(c) If alive, give age 5-9 years  
7. Birth date of deceased (mo., day, yr.) July 3d. 1893 (1893)  
8. AGE: Years 54 Months 5 Days 23 If less than one day  
9. Birthplace Greensboro Md.  
(Town, county, and state)  
10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER  
12. Name D. Mc Muller  
13. Birthplace md.  
14. Maiden name Laura Lane  
15. Birthplace md.

16. Informant William E. Stubbs  
Address Henderson md.

17. Burial Date thereof Aug. 29. 47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greensboro  
Location Greensboro md.

18. Funeral director Raymond B. Rawlings  
Address Greensboro md.

19. 8/29 19 47 C. Clark Smith  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 19 47 at 11:15 P

21. I CERTIFY that death occurred on the date above stated; the deceased deceased from 1947 to 8/26 19 47  
and that I last saw him alive on 8/26 19 47

Immediate cause of death Heart Failure DURATION  
Due to Organic Heart Several years  
(Calculus)

Other conditions.

(Include pregnancy within 3 months of death)

Major findings of operations.

Autopsy results.  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of.

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Silver M. D. or other  
Address Goldsboro Md. Date signed 8/29/47

RECEIVED  
SEP 3 1947  
BUREAU U.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06881

Reg. Dist. No. 66

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date read by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

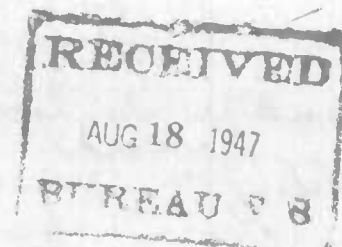
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 61

06882

## 1. PLACE OF DEATH:

County Caroline  
 City or town Greensboro  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution? ✓

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Greensboro  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Rella Hutson Vickery

## 3. (b) Social Security Number

213-22-6068

4. Sex

F.

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

William J.

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

Feb. 9 - 1886

8. AGE:

Years

61

Months

6

Days

10

If less than one day

hrs.

min.

9. Birthplace

Pools Mill Maryland  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name William G. Pinder

13. Birthplace

Md.

14. Maiden name

Clara Jane Hersey

15. Birthplace

Maryland

16. Informant

Mrs. Mattie Englem

Address

Harrington, Md.

17. Burial

Greensboro

Cemetery or crematory

Greensboro, Md.

18. Funeral director

R. B. Rawlings

Address

Greensboro Md.

19. Date of death

Aug. 21, 1947

(Date rec'd by registrar)

Registrar

L. Mae Pippin

Address

Greensboro Md.

Date signed

Aug 21 1947

Initials

209

Initials

1047

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 19, 1947, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19, 1947, to Aug 19, 1947and that I last saw him alive on Aug 19, 1947

Immediate cause of death

Chronic Myocarditis

Due to

Due to

Other conditions

None

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Greensboro Md.

Date signed

Aug 21 1947

Initials

209

Initials

1047

MARGIN RESERVED FOR BINDING

VS A15

9-475-151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06883

Reg. Dist. No. 62

## 1. PLACE OF DEATH:

County Caroline  
 City or town Denton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? life  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Caroline  
 City or town Denton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Addie Lavinia Wilson

## 3. (b) Social Security Number

4. Sex

7

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 23, 1867  
 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 79 Months 9 Days 7 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Denton, Caroline, Md.  
 (Town, county, and state)

10. Usual occupation School Teacher

## 11. Industry or business

12. Name James Wilson

13. Birthplace Maryland

14. Maiden name Susan Hallbrook

15. Birthplace Maryland

16. Informant Mrs. Sadie Thompson

Address 4175 Salem St. Frankfort, Pa.

17. Burial Date thereof Aug 15, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Denton

Location Denton, Maryland

18. Funeral director Funeral Home

Address Denton, Maryland

19. 8/15 19 47 M. D. George  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 19 47 at 04:15 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 19 47 to Aug 12 19 47

and that I last saw her alive on August 11 19 47

Immediate cause of death Chor. Myocarditis DURATION

Due to Coronary Arteriosclerosis

Due to Cardiac Devascular Disease

Other conditions Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Chas. H. Houshick D. O. \_\_\_\_\_

Address Frederick Date signed 1947

RECEIVED

AUG 18 1947

BUREAU 78